Testimony of Ira R. Katz, M.D., Ph.D.
To the Policy Committee
Of the White House Conference on Aging
Efficacy of Mental Health Interventions
January 24, 2005

My name is Ira Katz. I am a representative of the American Geriatrics Society to the National Coalition on Mental Health and Aging. I am a Professor of Psychiatry at the University of Pennsylvania and Director of an NIMH-supported Advanced Center for Interventions and Services Research and a VA-supported Mental Illness Research Education and Clinical Center. You have already heard that mental illness is common in late life; that it can be diagnosed as precisely as the other illnesses of late life; that it is a major public health problem in terms of the suffering, disability, and worsening of other medical conditions, and deaths that it causes; and that it is associated with staggering costs for patients, families, and our Nation as a whole. I am here to give an important and optimistic message- treatment works.

The theme that treatment works for the mental disorders of late life has been demonstrated in a growing scientific literature and through its impact on critical documents including the 2003 final report of the President's New Freedom Commission on Mental Health; the 2002 report "Reducing Suicide: A National Imperative" from the Institute of Medicine; the 2001 report "Older Adults and Mental Health: Issues and Opportunities" from the Administration on Aging; the 1999 Surgeon General's Report on Mental Health; and others. Nowhere else is the first goal of the New Freedom Commission, ensuring that "Americans understand that mental health is essential to overall health," as critical as it is in late life. As we use this occasion to take stock of our field, we should celebrate the growth of the evidence base and the fact that we know that treatment works because research works.

It is useful to talk about mental health interventions at multiple levels. At the most basic level are specific elements of treatment such as specific medications or therapies, next are algorithms that provide guidance as to how elements of treatment should be sequenced or combined to optimize outcomes, as well as programs that support the delivery of algorithm-based care, and, finally, there are the policies that can be facilitators or barriers of care. Here, our goal is to work toward ensuring that evolving policy is informed by knowledge of the effectiveness of mental health interventions in late life.

The largest body of research has been on late life depression where it has led to evidence for the efficacy of antidepressants, as well as psychotherapies including cognitive behavioral therapy, interpersonal therapy, problem solving and others. Treatment has been shown to work for depression, not just in medically healthy older people but in those with illnesses of late life as diverse as Alzheimer's disease, arthritis, cancer, cardiac disease, chronic obstructive pulmonary disease, diabetes, Parkinson's disease, stroke, and others. It works not just in mental health care settings, but also in primary care,

rehabilitation units, home care, and nursing homes. Moreover, research has also shown that treatment works not just to get people well, but to keep them well.
Findings from three large national projects, the NIMH-supported PROSPECT study, the Hartford Foundation-supported IMPACT study, and the VA- and SAMHSA-supported PRISME study have demonstrated that medications and psychotherapy can be incorporated into algorithms and programs that can be delivered to older people in primary care, and that this leads to improved access and outcomes. Moreover, we are beginning to show that the delivery of treatments for depression has effects that go beyond the reduction of depressive symptoms to include associated outcomes such as improved functioning, increased control of diabetes, reductions in pain related to arthritis, and decreased suicidal ideation.

For Alzheimer's disease and related dementing illnesses, there is evidence for a real but modest effect of medications in improving cognitive performance, as well as a robust effect of caregiver-centered treatment and support groups in delaying nursing home placement. There is also evidence that treatment works for the psychoses, depressions, and behavioral symptoms that occur as components or complications of dementia for most patients with Alzheimer's disease. Atypical antipsychotic medications have positive effects on behavioral symptoms such as agitation and aggression, and serotonin uptake inhibitors have benefits for the depression of Alzheimer's disease. There is also evidence for effects of specific activities, behavioral treatment, and environmental interventions for behavioral symptoms, especially in nursing homes, and for the benefits of caregiver-mediated behavioral treatment for the depression of Alzheimer's disease.

We know somewhat less about effective treatments for anxiety disorders in the elderly, but the emerging literature appears to confirm the effectiveness of both medications and specific psychotherapies. There is also need for more research about the treatment of the serious mental illnesses such as schizophrenia and bipolar disease that can begin in young adulthood and persist into old age; here the ongoing focus is on both the manner with which pharmacological treatments should change as the brain and body age as well as on opportunities for rehabilitation, even in late life.

In reviewing the outcomes of interventions, it is also important to acknowledge that elderly people, especially individuals with significant psychiatric-medical comorbidity, are those who are most vulnerable to side effects from medications, and that certain side effects may occur specifically in older people. Recent findings include the risks of cerebrovascular events from atypical antipsychotic medications in nursing home residents and risks of both falls and bleeding from serotonin reuptake inhibitors. Thus, delivering treatment to older people must require careful evaluation of benefits versus risks, close monitoring of outcomes, and expertise about the process of aging and the diseases of both the body and mind that all too often accompany it.

What are the policy issues that should follow from the evidence for the effectiveness of our interventions for the mental disorders of late life?

First and foremost, Medicare and Medicaid policies should make these treatments available to all of those in need. The basic payment and training issues will be discussed by others. However, I would like to mention some policy related issues that follow directly from the findings discussed here.

With the current evidence for the effectiveness of programs integrating mental health with primary care, Medicare policy should include payment for care management programs to support a role for primary care providers in collaboration with mental health professionals in managing the mental disorders in late life.

With respect to medications, there is a need to recognize the unique issues of older individuals with a more stringent geriatric rule for the FDA for the testing of new medications in old people; increased post-marketing surveillance for side effects of medications in the elderly; and attention to the facts of aging and the resulting drug-drug and drug-disease interactions in developing the Medicare formulary and Part D policies.

With respect to psychotherapy, recognizing that compelling evidence for the effectiveness of specific therapies has developed in parallel with evidence for the side effects as well as the benefits of psychiatric medications should lead to a reevaluation of Medicare payment policies for psychotherapy. The value of reevaluating payment for psychotherapy is strengthened by the changing pattern of the costs of care related to the implementation of Medicare Part D.

Finally, it is important to acknowledge the engine that has driven much of the research we have discussed, the Aging Branch of the extramural research program at NIMH. There should be ongoing recognition and support of this Branch as a critical component of the overall Federal investment in Aging research.